Background

Hospitals that serve a large number of uninsured patients and Medicaid enrollees receive additional Medicaid disproportionate share hospital (DSH) payments. As established in the Balanced Budget Act of 1997 (BBA), the Federal share of Medicaid DSH payments was capped at specified amounts for each state for each of the fiscal years 1998 through 2002. For most states, those specified amounts declined over the 5-year period. A state's allotment for FY2003 and for later years was to equal its allotment for the previous year increased by the percentage change in the consumer price index for urban consumers (CPI-U) for the previous year. In addition, each state's DSH payment for FY 2003 and subsequent years was limited to no more than 12% of spending for medical assistance in each state for that year.

The "Benefits Improvement and Protection Act of 2000" (BIPA) provided states with a temporary reprieve from the declining allotments by establishing a special rule for the calculation of DSH allotments for 2 years, raising allotments for fiscal years 2001 and 2002. The provision also clarified that the FY2003 allotments were to be calculated as specified above, using the lower, pre-BIPA levels for FY2002 in those calculations.

Certain "extremely low DSH states" received additional assistance. Extremely low DSH states were those states whose FY1999 Federal and state DSH expenditures (as reported to CMS on August 31, 2000) were greater than zero but less than 1% of the state's total medical assistance expenditures during that fiscal year. DSH allotments for the extremely low DSH states for FY2001 were equal to 1% of the state's total amount of expenditures under its plan for such assistance during that fiscal year. For subsequent fiscal years, the allotments for an extremely low DSH state were equal to its allotment for the previous year, increased by the percentage change in the CPI-U for the previous year, subject to a ceiling of 12% of that state's total medical assistance payments in that year.

Finally, the BBA required each state to submit to the Secretary an annual report describing the disproportionate share payments made to each disproportionate share hospital (DSH) and the methodology used by the state for prioritizing payments to such hospitals.

New Provision in the Act

DSH Payments

- Provides a temporary one-year 16% increase in DSH allotments for FY 2004 without regard to the 12% limit described above. Thereafter, allotments stay at the FY 2004 level subject to the 12% limit until the year in which the allotments as calculated under BIPA catch-up with the new provision's allotments, at which point allotment levels are those of the previous year increased by CPI-U subject to the 12% limit.

- Allotments for certain extremely low DSH states are increased by 16% for each of five fiscal years 2004 through 2008. For FY 2009 and each succeeding fiscal year, the allotment levels will be those for the previous year increased by the CPI-U. Qualifying states are those which had DSH expenditures for FY 2000 that were greater than zero but less than 3% of a state's total medical assistance expenditures during that fiscal year.

- Establishes a contingent DSH allotment, subject to the 12% cap, for FY 2004 or FY 2005 for Tennessee and Hawaii should these states lose their state-wide section 1115 waivers, which currently do not provide for a state-specific DSH allotment.

Reporting Requirements

- With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a state, as a condition of receiving Medicaid matching payments, to submit an annual report that:
    - Identifies each DSH hospital that received a payment adjustment for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding year; and,
    - Other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments for the preceding fiscal year.
- States must also submit to the Secretary an independent certified audit that verifies:
    - How much hospitals in the state have reduced their uncompensated care costs to reflect the total amount of claimed DSH expenditures;
    - That payment to hospitals complies with the requirements of the statute that establish hospital-specific payment ceilings;
    - That only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to eligible individuals are included in the calculation of these hospital-specific limits;
    - That the state included all payments including supplemental payments, in the calculation of such hospital-specific limits; and,
    - That the state has separately documented and retained a record of all its costs, claimed expenditures, uninsured costs in determining payment adjustments, and any payments made on behalf of the uninsured from payment adjustments.

Special Rule for Certain Publicly-owned Regional Medical Centers

- Permits states to use, as the non-Federal share of Medicaid, funds that are transferred from or expenditures that are certified by a defined, publicly-owned regional medical center in another state so long as the Secretary determines that the use of these funds is proper and in the interest of the Medicaid program. The statute defines a qualifying center as one that: provides level 1 trauma and burn care services; provides level 3 neonatal care services; is obligated to serve patients, regardless of state of origin; is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 states; serves as a tertiary care provider for patients residing within a 125 mile radius; and, meets the criteria for a DSH hospital defined in section 1923 of the Social Security Act in at least one state other than the one in which the center is located. This provision is effective through December 31, 2005.